

## EDITORIAL

## The campaign to revitalise academic medicine kicks off

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Most cardiologists will be aware of the problems that exist at present in academic medicine, and the fact that many of the most able academic doctors do not go into academe. The inevitable consequence is that progress is slowed. The *BMJ* is spearheading a campaign to revitalise this issue and have appointed Professor Peter Tugwell to coordinate this project—one of his first steps was to write an editorial which appeared simultaneously in the *BMJ* and the *Lancet* in March 2004. This editorial is reprinted below so as to bring this very important issue to the notice of the cardiological community.

The *BMJ* and a range of partners, including other journals published by the BMJ Publishing Group, *Lancet*, *Canadian Medical Association Journal*, *Dutch Journal of Medicine*, *Medical Journal of Australia*, *Croatian Medical Journal*, the Academy of Medical Sciences, and many others have initiated a project to bring people together to debate whether the existing structure of academic medicine is still fundamentally sound and, if not, to propose alternatives to it.<sup>1</sup> I have taken on the challenge of coordinating this project, and I extend an invitation to readers all over the world to join me in this exciting enterprise.

To achieve the project's broad goals (box 1) we begin from the position that "more of the same" is not enough. We need to be free to propose radical changes to the fundamental nature of academic medicine (is the balance between bench and applied research all wrong?); its name (should it become "academic healthcare" or

should we drop "academic"?); its home base (are hospitals the wrong place to train doctors?); its relation to service (why are they so often far apart?); its methods of training and certification (should medical education be lecture based and far shorter?); and its responsibilities (should it be held accountable for inequities in health care at the global level?).

Our approach will be inclusive and is designed to ensure a broad input of opinions. Rather than allowing the process to be taken over by a few experts with vested interests, we will build consensus by inviting an exhaustive range of global stakeholders to contribute their views. We are especially interested in the views of the "customers" of academic medicine—patients, politicians, practitioners, the public. Anyone can contribute their views right now, today, as a rapid response to this article at [bmj.com](http://bmj.com). In addition, our new project webpage is under development ([www.bmj.com/academicmedicine](http://www.bmj.com/academicmedicine)), and this will contain regular campaign updates, news, and collected resources.

The proposed structure is as follows. The pivotal group will be an international working party whose composition will include knowledge and competency across the dimensions of global health and basic to applied healthcare research, representing the range of constituents (medical students, postgraduates, junior faculty, established academics—especially women). Supported by four advisory groups (box 2) and made up of approximately eight individuals, the

**Box 1: Goals of the project**

Development of strategy on the following issues:

- How should academic medicine look in the 21st century?
- How can we increase the impact of academic medicine on the rest of medicine and on health and healthcare?
- How should academic medicine be positioned internationally within medicine and also in the wider intellectual arena?
- How can recruitment to and job satisfaction of those working in academic medicine be increased?

**Box 2: Four advisory groups**

- Perspectives forum—patients, health professionals, government representatives, and medical unions
- Ad hoc consultants—providing systematic reviews and other factual summaries about the efficacy of different educational, organisational, and administrative approaches, and trends in human resources in academic medicine
- Communications consortium—disseminating surveys, drafts, and reports to everybody who is joined up to the campaign or may want to give input
- International advisory panels—deans, chairs, and funders whose support could help establish funding, profile, and implementation; also used as an ongoing sounding board

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working party will begin by answering four questions. Firstly, what are the roles of academic medicine?

Secondly, how well is academic medicine carrying out these roles? Responses to the earlier *BMJ* editorial launching this initiative have already nominated a wide array of (but no clear consensus about) perceived failures, including failing to serve the public good, lack of a global perspective, an unnecessary dichotomy between education and research, various shortcomings in medical education, and inadequate numbers of and career paths for well trained medical academics.<sup>2</sup>

Thirdly, why is academic medicine failing to fulfil its roles? Reasons might include inadequate leadership, a failure to translate basic discoveries into benefits for patients, inappropriate incentives to take up or maintain an academic career (especially among women), deficient mentoring for aspiring academics, lack of appreciation of the benefits of academic medicine by elected representatives, and poor integration with other health services. Many of the reasons will be economic—the salaries and resources needed for research and teaching make academic medicine unattractive currently—but we need to examine ethical and moral explanations as well.

Finally, for each failure, what ought to be done about it? Given current economic constraints in countries with high and low income, special attention will go to strategies that call for no additional funding. We will, however, welcome strategies that call for the reallocation of current funding. At the policy level, we welcome strategies for how academic medicine can contribute to national and global health. These strategies will be combined and formulated into concrete proposals for action.

We need your support and input. To nominate a member of the working party, join an advisory group, or register your experiences and views, send a rapid response to [bmj.com](mailto:bmj.com)

or contact our project manager, Jocalyn Clark, at [jclark@bmj.com](mailto:jclark@bmj.com).

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**Competing interests:** PT received travel and research support from pharmaceutical companies for over 30 years. This support has permitted research associates to work on methodological projects of no commercial interest, has supported students and fellows who otherwise wouldn't have been able to get an education, and has provided partial support for the planning and organisation of scientific meetings in which they had no say about subject matter, content, or speakers. His randomised trials of cyclosporine published in the *Lancet* and *New England Journal of Medicine* were funded in part but never in whole by pharmaceutical firms, who had no access to the emerging data, no control over whether or when the studies stopped, and no veto power over any publications or presentations. PT is editor of the Cochrane Musculoskeletal Review Group, which has received unrestricted grants for staff support in carrying out systematic reviews, some of which failed to draw favourable conclusions about donor's drugs.

While PT was Chair of Medicine at the University of Ottawa a policy was introduced to prohibit pharmaceutical firms from solo support of department educational rounds or from any say in content. He also enforced a policy of using generic names. PT has never received awards from pharmaceutical firms. When serving on the US Government National Science Panel examining the relationship between silicone breast implants and connective tissue disorders, PT was certified by a US District Court judge to be free of any industry influence.

## REFERENCES

- 1 Clark J, Smith R. BMJ publishing group to launch an international campaign to promote academic medicine. *BMJ* 2003;**327**:1001–2.
- 2 Anon. Academic medicine: resuscitation in progress. *CMAJ* 2004;**170**:309.

## IMAGES IN CARDIOLOGY .....

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### Complete regression of pulmonary vein aneurysm caused by mitral regurgitation

Three years before admission a 19 year old man underwent prosthetic aortic valve replacement for congenital aortic stenosis. A patch enlargement of the aortic valve ring was performed through extension of the aortic incision into the anterior mitral leaflet. Postoperatively a mild mitral regurgitation was noticed.

At presentation the patient complained of weakness and lack of energy.

A right sided pericardial mass was seen on routine chest x ray. Transoesophageal echocardiography revealed a severe mitral regurgitation caused by a defect in the base of the anterior mitral leaflet (left panel). Contrast enhanced magnetic resonance imaging demonstrated an aneurysm of the right inferior pulmonary vein (middle panel). The regurgitation jet was directed to the dilated pulmonary vein. Mitral valve repair was

performed with an additional Dacron patch. Six months later, there is no residual mitral insufficiency and the aneurysm has completely disappeared (right panel). The patient is free of symptoms.

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